

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0051381</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>BRIA OF COLUMBIA</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2025</u> to <u>09/30/2025</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>253 BRADINGTON DRIVE</u> <u>COLUMBIA</u> <u>62236</u>																									
Number City Zip Code																									
County: <u>MONROE</u>																									
Telephone Number: <u>(618) 281-6800</u> Fax # <u>(618) 281-6557</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>AVRUM WEINFELD</u></td></tr><tr><td>(Title) <u>CEO</u></td></tr><tr><td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>MITCH KOHANANOO</u> <u>PARTNER</u></td></tr><tr><td>(Firm Name & Address) <u>ACCOUNTING ASSOCIATES, LLC</u> <u>6201 W. HOWARD STREET SUITE 201, NILES, IL 60714</u></td></tr><tr><td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>AVRUM WEINFELD</u>	(Title) <u>CEO</u>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	Paid Preparer	(Date) _____	(Print Name and Title) <u>MITCH KOHANANOO</u> <u>PARTNER</u>	(Firm Name & Address) <u>ACCOUNTING ASSOCIATES, LLC</u> <u>6201 W. HOWARD STREET SUITE 201, NILES, IL 60714</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>												
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	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>																								
Date of Initial License for Current Owners: <u>07/01/2022</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ "Sub-S" Corp.																								
	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630																							
Name: <u>MITCH KOHANANOO</u> Telephone Number: <u>(847) 675-3585</u>																									
Email Address: _____																									

Facility Name & ID Number BRIA OF COLUMBIA # 0051381 Report Period Beginning: 01/01/2025 Ending: 09/30/2025

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	119	Skilled (SNF)	119	32,487	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	119	TOTALS	119	32,487	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF			601	117		2,266	838	3,822	8
9	SNF/PED									9
10	ICF	4,503	15,101			3,330		778	23,712	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	4,503	15,101	601	117	3,330	2,266	1,616	27,534	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 84.75%

D. How many bed reserve days during this year were paid by the Department? _____ (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 07/01/2022

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 07/01/2022 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 119

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☐ NO ☐

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number

BRIA OF COLUMBIA

0051381

Report Period Beginning:

01/01/2025

Ending:

09/30/2025

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	140,628	17,343	185,471	343,442		343,442		343,442			1
2	Food Purchase		215,691		215,691		215,691	(200)	215,491			2
3	Housekeeping		14,813	201,910	216,723		216,723		216,723			3
4	Laundry		5,410	134,532	139,942		139,942		139,942			4
5	Heat and Other Utilities			155,126	155,126		155,126	763	155,889			5
6	Maintenance	95,072	70,485	34,276	199,833		199,833	8,351	208,184			6
7	Other (specify):* Scavenger			16,698	16,698		16,698	146	16,844			7
8	TOTAL General Services	235,700	323,742	728,013	1,287,455		1,287,455	9,060	1,296,515			8
	B. Health Care and Programs											
9	Medical Director			22,000	22,000		22,000		22,000			9
10	Nursing and Medical Records	2,936,802	159,833	503,352	3,599,987		3,599,987	48,448	3,648,435			10
10a	Therapy	244,206		15,663	259,869		259,869		259,869			10a
11	Activities	84,656	1,750	1,293	87,699		87,699		87,699			11
12	Social Services	49,229	461	1,293	50,983		50,983		50,983			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,314,893	162,044	543,601	4,020,538		4,020,538	48,448	4,068,986			16
	C. General Administration											
17	Administrative	200,418			200,418		200,418	22,882	223,300			17
18	Directors Fees											18
19	Professional Services			260,287	260,287		260,287	(144,762)	115,525			19
20	Dues, Fees, Subscriptions & Promotions			35,566	35,566		35,566	(14,064)	21,502			20
21	Clerical & General Office Expenses	309,150	5,429	145,280	459,859		459,859	(24,197)	435,662			21
22	Employee Benefits & Payroll Taxes			502,580	502,580		502,580		502,580			22
23	Inservice Training & Education			10,302	10,302		10,302	67	10,369			23
24	Travel and Seminar			14,361	14,361		14,361	(1,983)	12,378			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			210,079	210,079		210,079	933	211,012			26
27	Other (specify):*			162,014	162,014		162,014	(140,366)	21,648			27
28	TOTAL General Administration	509,568	5,429	1,340,469	1,855,466		1,855,466	(301,490)	1,553,976			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,060,161	491,215	2,612,083	7,163,459		7,163,459	(243,982)	6,919,477			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES				PAGE 3 COLUMN 3 OTHER			
LINE		SCHED REF	TOTAL	LINE		SCHED REF	TOTAL
1	DIETARY			10	NURSING		
	DIETITIAN CONSULTANT	XVIII B 35-2	26,229		CONTRACT NURSING	XVIII C 53-2	486,387
	REPAIRS & MAINTENANCE				LABORATORY & XRAY EXPENSE		1,859
	CONTRACTED DIETARY SERVICES		159,242		PURCHASED SERVICES		
			185,471		PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	
3	HOUSEKEEPING			10a	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	
	CONTRACTED HOUSEKEEPING SERVICES		201,910		MEDICAL RECORDS CONSULTANT	XVIII B 37-2	
			201,910		PHARMACY CONSULTANT	XVIII B 39-2	6,032
4	LAUNDRY				UTILIZATION REVIEW FEES	XVIII B __-2	
	EQUIPMENT REPAIRS & MAINTENANCE				PHYSICIANS	XVIII B __-2	
	CONTRACTED LAUNDRY SERVICES		134,532		PSYCHIATRIC	XVIII B __-2	
			134,532		RN CONSULTANT	XVIII B 38-2	9,074
5	HEAT & OTHER UTILITIES						
	GAS HEAT		12,581				
	ELECTRICITY		79,809				
	WATER		58,876				503,352
	CABLE TV - LOBBY		3,860				
6			155,126	11	THERAPY		
	MAINTENANCE				PHYSICAL THERAPY SERVICES		
	GROUND MAINTENANCE		18,215		SPEECH THERAPY SERVICES		
	PAINTING & DECORATING				OCCUPATIONAL THERAPY SERVICES		
	BUILDING REPAIRS				REHABILITATION CONSULTANT	XVIII B __-2	
	MAINTENANCE TRAVEL				PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	7,569
	EQUIPMENT MAINTENANCE & REPAIR		563		OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	3,721
	ELEVATOR MAINTENANCE & REPAIR				RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	2,048
	OUTSIDE LABOR				SPEECH THERAPY CONSULTANT	XVIII B 43-2	2,325
	EXTERMINATING SERVICE						
	FIRE SERVICE		15,498				15,663
				12	ACTIVITIES		
					CABLE TV - PATIENT ROOMS		
7			34,276		ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,293
	OTHER			13			1,293
	SCAVENGER		16,698		SOCIAL SERVICES		
	SECURITY SERVICE				SOCIAL REHABILITATION SERVICES		
9					SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	1,293
			16,698		SOCIAL WORKER	XVIII B 45-2	
							1,293
	MEDICAL DIRECTOR				NURSE AIDE TRAINING		
	MEDICAL DIRECTOR FEES		22,000		NURSE AIDE TRAINING COSTS	XIII	0

LINE	V.COST CENTER EXPENSES	PAGE 3 COLUMN 3 OTHER	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION			
	PATIENT TRANSPORTATION			0
17	ADMINISTRATIVE			
	MANAGEMENT FEES	XIX B		0
18	DIRECTORS FEES			0
19	PROFESSIONAL SERVICES			
	DATA PROCESSING	XIX C	30,939	
	ADMINISTRATIVE CONSULTANTS	XIX C		
	PROFESSIONAL FEES	XIX C	62,748	
	BOOKKEEPING/ADMINISTRATIVE SERVICES		166,600	
				260,287
20	FEES,SUBSCRIPTIONS,PROMOTIONS			
	ENTERTAINMENT & MARKETING	VI 19 XIX F		
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	2,105	
	EMPLOYEE WANT ADS	XIX F	7,000	
	CONTRIBUTIONS	VI 20 XIX F		
	DUES & SUBSCRIPTIONS	XIX F	6,082	
	LICENSES & PERMITS	XIX F	2,780	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F		
	ADVERTISING-YELLOW PAGES	VI 28 XIX F		
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F		
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	16,017	
	HEALTH CARE WORKER BACKGROUND CHE	XIX F		
	PATIENT BACKGROUND CHECKS	XIX F	1,582	
				35,566
21	CLERICAL & GENERAL OFFICE EXPENSES			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		2,597	
	EQUIPMENT REPAIR & MAINTENANCE		89,794	
	OUTSIDE CLERICAL SERVICES			
	PENALTIES / OVERDRAFT CHARGES	VI 18	33,827	
	HOME OFFICE EXPENSE			
	THEFT & DAMAGE LOSS			
	TELEPHONE		19,062	
	MESSENGER SERVICE			
				145,280

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES	XIX D 303,888
	UNEMPLOYMENT COMPENSATION	XIX D 36,998
	WORKERS COMPENSATION INSURANCE	XIX D 72,134
	HOSPITALIZATION INSURANCE	XIX D 78,844
	EMPLOYEE BENEFITS - OTHER	XIX D 10,716
	EMPLOYEE PHYSICAL EXAMS	XIX D
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D
	PENSION/PROFIT SHARING PLANS	XIX D
		502,580
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	10,302
		10,302
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS	XIX G
	TRAVEL	XIX G 14,361
		14,361
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	
		0
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	210,079
		210,079
27	OTHER	
	BAD DEBTS	VI 24 162,014
		162,014

GRAND TOTAL COLUMN 3 OTHER

2,612,083

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			4,914	4,914		4,914	20,401	25,315			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,430	16,430		16,430	28,175	44,605			32
33	Real Estate Taxes							3,004	3,004			33
34	Rent-Facility & Grounds			653,902	653,902		653,902		653,902			34
35	Rent-Equipment & Vehicles			38,579	38,579		38,579	554	39,133			35
36	Other (specify):* RENT OFFICE			2,800	2,800		2,800	(2,800)				36
37	TOTAL Ownership			716,625	716,625		716,625	49,334	765,959			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		97,415	200,914	298,329		298,329		298,329			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			551,017	551,017		551,017		551,017			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		97,415	751,931	849,346		849,346		849,346			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,060,161	588,630	4,080,639	8,729,430		8,729,430	(194,648)	8,534,782			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	17,146	30		9
10	Interest and Other Investment Income	(24)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(200)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(33,827)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(162,014)	27		24
25	Fund Raising, Advertising and Promotional	(2,105)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(84,108)	22		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (265,132)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	70,484		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 70,484		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (194,648)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (16,017)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	MARKETING SALARIES	(63,982)	21	3
4	MARKETING TRAVEL	(4,109)	24	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(84,108)		49

Summary A

09/30/2025

[illegible]

Summary B

09/30/2025

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE PG OWNERSHIP-1						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	36	RENT OFFICE	\$ 2,800	IME REALTY CORPORATION		\$	\$ (2,800)	1
2	V								2
3	V	5	UTILITIES				763	763	3
4	V	6	MAINTENANCE				370	370	4
5	V	19	PROFESSIONAL FEES				33	33	5
6	V	26	INSURANCE				150	150	6
7	V	30	DEPRECIATION				1,209	1,209	7
8	V	32	INTEREST				1,359	1,359	8
9	V	33	RE TAX				3,004	3,004	9
10	V	21	OFFICE EXPENSE				186	186	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 2,800			\$ 7,074	\$ * 4,274	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	BOOKKEEPING/ADM SERVICES	\$ 166,600	BRIA HEALTH SERVICES, LLC		\$	\$ (166,600)	15
16	V								16
17	V	17	MANAGEMENT FEES-RELATED PARTIES				8,988	8,988	17
18	V	17	SALARIES-CFO				13,894	13,894	18
19	V	6	SALARIES-MAINTENANCE				6,415	6,415	19
20	V	10	SALARIES-A/R				48,448	48,448	20
21	V	21	SALARIES-CLERICAL RELATED PARTIES				2,112	2,112	21
22	V	21	SALARIES-CLERICAL				63,492	63,492	22
23	V	6	MAINTENANCE				1,566	1,566	23
24	V	7	SCAVENGER				146	146	24
25	V	19	PROFESSIONAL FEES				21,805	21,805	25
26	V	20	DUES,FEES,SUBSCRIPTIONS				4,058	4,058	26
27	V	21	OFFICE EXPENSE				7,822	7,822	27
28	V	23	SEMINARS				67	67	28
29	V	24	TRAVEL				2,126	2,126	29
30	V	26	INSURANCE				783	783	30
31	V	27	EMPLOYEE BENEFITS				21,648	21,648	31
32	V	30	DEPRECIATION				2,046	2,046	32
33	V	32	INTEREST				26,840	26,840	33
34	V	35	AUTO LEASE				264	264	34
35	V	35	EQUIPMENT RENTAL				290	290	35
36	V								36
37	V								37
38	V								38
39	Total			\$ 166,600			\$ 232,810	\$ * 66,210	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number

BRIA OF COLUMBIA

0051381

Report Period Beginning:

01/01/2025

Ending:

09/30/2025

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	BRIA OF CAHOKIA	CAHOKIA	LYDIA CARE CENTER	ROBBINS	BRIA HEALTH	SKOKIE	MANAGEMENT	1
2					SERVICES, LLC		SERVICES	2
3	BRIA OF BELLEVILLE	BELLEVILLE	BRIA OF ELMWOOD	ELMWOOD PARK				3
4					IME REALTY	SKOKIE	CORPORATE	4
5	BRIA OF GENEVA	GENEVA					OFFICE	5
6								6
7	BRIA OF FOREST EDGE	CHICAGO			WEISS MGMT	SKOKIE	MANAGEMENT/	7
8					GROUP, INC		CLERICAL	8
9	LAKE PARK CENTER	WAUKEGAN						9
10					DA WESTMONT	SKOKIE	MGMT CONSULT	10
11	BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO						11
12		HEIGHTS						12
13								13
14	BRIA OF WESTMONT	WESTMONT						14
15								15
16	BRIA OF PALOS HILLS	PALOS HILLS						16
17								17
18	BRIA OF RIVER OAKS	BURNHAM						18
19								19
20	BRIA OF ALTON	ALTON						20
21								21
22	BELLEVILLE HEALTHCARE CENTER	BELLEVILLE						22
23								23
24	BRIA OF GODFREY	GODFREY						24
25								25
26	BRIA OF WOODRIVER	WOODRIVER						26
27								27
28	BRIA OF MASCOUTAH	MASCOUTAH						28
29								29
30								30

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
Hours						Percent	Description	Amount			
1	ALLOCATIONS FROM BRIA HEALTH SERVICES LLC:								\$		1
2	ARIELLA WEIL	RELATIVE	ACCOUNTS PAYABLE					SALARY		21-7	2
3	MIRYAM CLEVS	RELATIVE	OFFICE CLERK		SEE			SALARY	2,112	21-7	3
4	FRED BERKOVITS	MEMBER	REGIONAL DIR		ATTACHED			MGMT FEES	8,988	17-7	4
5					SCHEDULE						5
6	ALLOCATION FROM DA WESTMONT:										6
7	AVRUM WEINFELD	MEMBER	CFO	33.33				SALARY	6,000	17-7	7
8	DANIEL WEISS	MEMBER	ADMINISTRATIV	33.33				SALARY	9,000	17-7	8
9											9
10	ALLOCATIONS FROM WESS MANAGEMENT GROUP:										10
11	NATAN WEISS	MEMBER	FINANCE/MGMT	16.67				MGMT FEES	13,500	17-7	11
12	DANIEL WEISS	MEMBER	ADMINISTRATIV	33.33				SALARY	17,852	17-7	12
13								TOTAL	\$ 57,452		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BRIA OF COLUMBIA # 0051381 Report Period Beginning: 01/01/2025 Ending: 9/30/2025

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization IME REALTY CORPORATION
Street Address 5151 CHURCH STREET
City / State / Zip Code SKOKIE, IL 60077
Phone Number (847) 933-9200
Fax Number (847) 674-5794

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	CENSUS DAYS	821,683	19	\$ 22,755	\$	27,534	\$ 763	1
2	6	MAINTENANCE	CENSUS DAYS	821,683	19	11,037		27,534	370	2
3	19	PROFESSIONAL FEES	CENSUS DAYS	821,683	19	975		27,534	33	3
4	26	INSURANCE	CENSUS DAYS	821,683	19	4,484		27,534	150	4
5	30	DEPRECIATION	CENSUS DAYS	821,683	19	36,102		27,534	1,209	5
6	32	INTEREST	CENSUS DAYS	821,683	19	40,569		27,534	1,359	6
7	33	RE TAX	CENSUS DAYS	821,683	19	89,649		27,534	3,004	7
8	21	OFFICE EXPENSE	CENSUS DAYS	821,683	19	5,537		27,534	186	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 211,108	\$		\$ 7,074	25

Facility Name & ID Number BRIA OF COLUMBIA # 0051381 Report Period Beginning: 01/01/2025 Ending: 9/30/2025

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization BRIA HEALTH SERVICES, LLC
Street Address 5151 CHURCH STREET
City / State / Zip Code SKOKIE, IL 60077
Phone Number (847) 933-9200
Fax Number (847) 674-5794

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	MANAGEMENT FEES-RELATED	wghtd avr hours	40	19	\$ 179,753	\$	2	\$ 8,988	1
2	17	SALARIES-CFO	CENSUS DAYS	821,683	19	414,635	414,635	27,534	13,894	2
3	6	SALARIES-MAINTENANCE	CENSUS DAYS	821,683	19	191,428	191,428	27,534	6,415	3
4	10	SALARIES-A/R	CENSUS DAYS	821,683	19	1,445,803	1,445,803	27,534	48,448	4
5	21	SALARIES-CLERICAL RELATED	wghtd avr hours	38	19	83,882	83,882	2	2,112	5
6	21	SALARIES-CLERICAL	CENSUS DAYS	821,683	19	1,894,762	1,894,762	27,534	63,492	6
7	6	MAINTENANCE	CENSUS DAYS	821,683	19	46,742		27,534	1,566	7
8	7	SCAVENGER	CENSUS DAYS	821,683	19	4,371		27,534	146	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	821,683	19	650,717		27,534	21,805	9
10	20	DUES,FEES,SUBSCRIPTIONS	CENSUS DAYS	821,683	19	121,115		27,534	4,058	10
11	21	OFFICE EXPENSE	CENSUS DAYS	821,683	19	233,414		27,534	7,822	11
12	23	SEMINARS	CENSUS DAYS	821,683	19	1,992		27,534	67	12
13	24	TRAVEL	CENSUS DAYS	821,683	19	63,442		27,534	2,126	13
14	26	INSURANCE	CENSUS DAYS	821,683	19	23,354		27,534	783	14
15	27	EMPLOYEE BENEFITS	CENSUS DAYS	821,683	19	646,030		27,534	21,648	15
16	30	DEPRECIATION	CENSUS DAYS	821,683	19	61,068		27,534	2,046	16
17	32	INTEREST	CENSUS DAYS	821,683	19	800,962		27,534	26,840	17
18	35	AUTO LEASE	CENSUS DAYS	821,683	19	7,877		27,534	264	18
19	35	EQUIPMENT RENTAL	CENSUS DAYS	821,683	19	8,649		27,534	290	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 6,879,996	\$ 4,030,510		\$ 232,810	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2	FORGE INVESTMENTS LLC	X		WORKING CAPITAL		07/05/22	400,000	254,308	07/05/28	7.0000	16,430		2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8	RELATED PARTY ALLOCATION										28,199		8
9	TOTAL Facility Related						\$ 400,000	\$ 254,308				\$ 44,629	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$	\$				\$	14
15	TOTALS (line 9+line14)						\$ 400,000	\$ 254,308				\$ 44,629	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	7
Assessed Value from Real Estate Tax Bill:	2024	1,231,010	8		
Real Estate Tax Bill for Calendar Year:	2020		9		
	2021		10		
	2022		11		
	2023		12		
	2024		13		
				FOR BHF USE ONLY	
				14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
				15	PLUS APPEAL COST FROM LINE 5 \$ 15
				16	LESS REFUND FROM LINE 6 \$ 16
				17	AMOUNT TO USE FOR RATE CALCULATION \$ 17

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

BRIA OF COLUMBIA

COUNTY

MONROE

FACILITY IDPH LICENSE NUMBER

0051381

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2024.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 04-17-481-004-000	LONG TERM CARE PROPERTY	\$ 50,872.54	\$ 50,872.54
2. 04-17-481-005-000	LONG TERM CARE PROPERTY	\$ 628.98	\$ 628.98
3. 04-17-481-028-000	LONG TERM CARE PROPERTY	\$ 22,802.18	\$ 22,802.18
4.		\$	\$
5.		\$	\$
6.		\$	\$
7. 10-16-400-033-0000	IME ALLOCATION	\$	\$ 3,004.00
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 74,303.70	\$ 77,307.70

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies of their original second installment tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,709 B. General Construction Type: Exterior BRICK Frame CONCRETE/STEEL Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases? YES
H. Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? NO
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number **BRIA OF COLUMBIA**

0051381

Report Period Beginning:

01/01/2025

Ending:

09/30/2025

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7	IME-BLDG				17,492	449		449			7
8	RELATED PARTY -IMPR				61,565	1,570		1,570			8
	Improvement Type**										
9	PARKING LOT: PUT 1 COAT OF MAC-B52 SEALER WITH SAND,			2022	12,750		15	496	496	2,409	9
10	STRIPE PARKING LOT										10
11	BULDING EXTERIOR: REPLACEMENT 2-SPLIT SYSTEM, FURNISH			2022	14,779		27.5	313	313	1,409	11
12	AND INSTALL NEW CONDENSERS, COILS, AHU AND FURNACE.										12
13	VISION LINK II COMPUTER CONSOLE:INSTALLATION PACKAGE										13
14	INCLUDES LABOR, PROGRAMMING,TESTING, TRAINING			2023	22,745		15	884	884	3,916	14
15	REPLACE EXTERIOR DOORS :RIM PANIC DEVICE, RLM CYLINDER,										15
16	SURFACE CLOSER, DROP PLATE , DOOR SWEEP			2023	9,995		27.5	212	212	938	16
17	12 ROOM: INSTALL NEW FLOORING, BLOCKING, PAINT										17
18	WALLS, HIDE WIRES FOR TELEVISIONS			2023	49,500		27.5	1,050	1,050	4,650	18
19	FURNISHG & INSTALL AMERICAN STANDARD 3 PHASE A/C,										19
20	5TON A-COIL			2024	7,580		15	295	295	800	20
21	INSTALL WATER SOFTENER :RE-PIPE WATER LINES, CONTROLLER										21
22	HUB, DROP LEAK DEDECTOR			2024	26,955		15	1,048	1,048	2,845	22
23	FIRE PROTECTION SYSTEM: ELECTRIC ALARMS, NITROGEN										23
24	GENERATOR, ELECTRIC WIRING, SPRINKLERS, PAINTING			2024	556,872		27.5	11,813	11,813	32,063	24
25	FURNISH AND INSTALLED NEW CONDENSOR			2024	6,890		15	268	268	727	25
26	FURNISH AND INSTALL 100-GALON WATER HEATER			2024	18,177		15	707	707	1,919	26
27	REPLACE A NEW FURNACE AND AC UNIT IN THE ATTIC ABOVE										27
28	THE KITCHEN AREA			2024	16,450		15	640	640	1,737	28
29	FURNISH AND INSTALLED NEW CHECK AND RELIEF VALVES			2024	3,835		15	149	149	404	29
30											30
31											31
32											32
33											33
34						666			(666)		34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 825,585	\$ 2,685		\$ 19,893	\$ 17,208	\$ 53,816	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 53,887	\$ 4,248	\$ 4,186	\$ (62)	8-10	\$ 16,505	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	RELATED PARTY		1,236	1,236				74
75	TOTALS	\$ 53,887	\$ 5,484	\$ 5,422	\$ (62)		\$ 16,505	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 879,472	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 8,169	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 25,315	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,146	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 70,321	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 253 BRADINGTON DRIVE LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	119	07/01/22		\$ 653,902	10		3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 653,902			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
-

9. Option to Buy: ☐ YES ☒ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: \$ 23,003 Description: SEE ATTACHED SCHEDULE
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	FACILITY	2022 FORD RAM PROMASTER	#####	15,576	18
19					19
20					20
21	TOTAL		\$ #####	\$ 15,576	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

10. Effective dates of current rental agreement:
- Beginning 07/01/2022
- Ending 06/30/2032

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.		\$
13.		\$
14.		\$

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

THIS FACILITY HIRES ONLY CERTIFIED NURSING AIDES

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 66,820	\$		\$ 66,820	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			30,692			30,692	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			103,402			103,402	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				69,320		69,320	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY	39-2					20,168		20,168	13
	Other (specify): IV THERAPY, RENTAL	39-2					7,927		7,927	
14	TOTAL			\$		\$ 200,914	\$ 97,415		\$ 298,329	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 551,968	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 86,966)	2,080,095		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	121,497		6
7	Other Prepaid Expenses	13,818		7
8	Accounts Receivable (owners or related parties)	924,604		8
9	Other(specify): R/E/T ESCROW DEPOSIT	3,471		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,695,453	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	18,305		15
16	Equipment, at Historical Cost	53,887		16
17	Accumulated Depreciation (book methods)	(53,986)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): REPLACEMENT RESERVE	3,471		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 21,677	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,717,130	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,593,302	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	301,427		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,894,729	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	254,308		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 254,308	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,149,037	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,568,093	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,717,130	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,465,222	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,465,222	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	102,871	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 102,871	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,568,093	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BRIA OF COLUMBIA

0051381

Report Period Beginning: 01/01/2025

Ending: 09/30/2025

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,213,404	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,213,404	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	329,983	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 329,983	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	24	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 24	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	QIP PAYMENTS	124,568	28
28a	C.N.A. WAGE PASS, ITT REBATE PROGRAM	200,216	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 324,784	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,868,195	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,287,455	31
32	Health Care	4,020,538	32
33	General Administration	1,855,466	33
	B. Capital Expense		
34	Ownership	716,625	34
	C. Ancillary Expense		
35	Special Cost Centers	298,329	35
36	Provider Participation Fee	551,017	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,729,430	40
41	Income before Income Taxes (line 30 minus line 40)**	138,765	41
42	Income Taxes	(35,894)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 102,871	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,134,419.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	3,803,784.00	45
46	MMAI-Medicaid is the Primary Payer	150,256.00	46
47	MMAI-Medicare is the Primary Payer	80,815.00	47
48	Private Pay	895,088.00	48
49	Medicare Part A	1,567,296.00	49
50	Other-(specify) HOSPICE	196,167.00	50
51	Other-(specify) INSURANCE	385,579.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,213,404	56

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,360	1,543	\$ 92,350	\$ 59.85	1
2	Assistant Director of Nursing	900	924	54,966	59.49	2
3	Registered Nurses	2,348	2,457	100,039	40.72	3
4	Licensed Practical Nurses	18,994	20,805	931,073	44.75	4
5	CNAs & Orderlies	54,182	59,709	1,589,166	26.62	5
6	CNA Trainees					6
7	Licensed Therapist	4,441	4,879	244,206	50.05	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,336	1,540	32,500	21.10	9
10	Activity Assistants	2,867	3,155	52,156	16.53	10
11	Social Service Workers	1,432	1,539	49,229	31.99	11
12	Dietician					12
13	Food Service Supervisor	744	776	17,902	23.07	13
14	Head Cook	1,246	1,300	25,199	19.38	14
15	Cook Helpers/Assistants	4,953	5,155	97,527	18.92	15
16	Dishwashers					16
17	Maintenance Workers	4,019	4,271	95,072	22.26	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,640	3,141	200,418	63.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,561	10,381	309,150	29.78	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,296	1,361	35,313	25.95	31
32	Other Health C: Care Plan Coord	2,744	3,078	133,895	43.50	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	115,063	126,014	\$ 4,060,161 *	\$ 32.22	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 26,229	1-3	35
36	Medical Director	O	22,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	6,032	10-3	39
40	Physical Therapy Consultant	L	7,569	10a-3	40
41	Occupational Therapy Consultant	Y	3,721	10a-3	41
42	Respiratory Therapy Consultant		2,048	10a-3	42
43	Speech Therapy Consultant	F	2,325	10a-3	43
44	Activity Consultant	E	1,293	11-3	44
45	Social Service Consultant	E	1,293	12-3	45
46	Other(specify) Psychiatric	S	0	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 72,510		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	6,267	\$ 322,569		50
51	Licensed Practical Nurses	1,066	48,792		51
52	Certified Nurse Assistants/Aides	4,093	115,026		52
53	TOTAL (lines 50 - 52)	11,426	\$ 486,387		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

BRIA OF COLUMBIA
LEGAL EXPENSES
12/31/2025

INVOICE DATE	FIRM NAME	DESCRIPTION OF SERVICE	AMOUNT
3/30/2025	BRIAN A STINES PC	COLLECTIONS	62
6/29/2025	BRIAN A STINES PC	COLLECTIONS	2,102
2/1/2025	HINSHAW & CULBERTSON	APPEARED FOR & ATTENDED IDPH STATUS HEARING	245
2/28/2025	HINSHAW & CULBERTSON	REVIEW AND ANALYSIS OF IDPH FINAL ORDER	70
3/31/2025	HINSHAW & CULBERTSON	APPEARED FOR & ATTENDED IDPH STATUS HEARING	247
5/1/2025	HINSHAW & CULBERTSON	SETTLEMENT NEGOTIATIONS WITH IDPH	534
2/28/2025	JACKSON LEWIS P.C.	COMPLETE FULL REGULAR RATE ANALYSIS	3,000
1/31/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
2/1/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
3/31/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
4/30/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
5/31/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
6/30/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
7/31/2025	STONE, MCGUIRE & SIEGEL	COMPLIANCE PROGRAM PROTOCOLS	700
TOTAL			11,160

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	6,082
	6,082 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	16,017
	16,017 Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)	22,099
	22,099 Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$	26,951	Line	10-2
----	---------------	------	-------------
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$	551,017
----	----------------

This amount is to be recorded on line 42 of Schedule V.
- (8)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

NO If YES, attach an explanation of the allocation.

- (9)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

YES
- (10)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$	N/A	Has any meal income been offset against related costs?	Indicate the amount.	\$	
----	------------	--	----------------------	----	--
- (12)

Travel and Transportation

a. Are there costs included for out-of-state travel?

NO

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

NO

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

5%

d. Have vehicle usage logs been maintained?

NO

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

NO

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

YES

g. Does the facility transport residents to and from day training?

NO

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

N/A
- (13)

Has an audit been performed by an independent certified public accounting firm?

NO

Firm Name:
- (14)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

YES
- (15)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

YES

Attach invoices and a summary of services for all architect and appraisal fees.